4. THE HEALTH STRATEGY AND SOCIO-ECONOMIC INEQUALITIES IN HEALTH

RICHARD LAYTE AND BRIAN NOLAN

Introduction

Shaping a healthier future (Department of Health, 1994) has been successful in orientating health policy and denoting particular areas in need of attention and development. However, a rather limited role was given to socio-economic inequalities and the processes underlying these in the strategy document, and this area has been of growing concern both in Ireland and elsewhere. Health inequalities and designing policies towards reducing them will thus have much greater prominence in a new strategy, so this section highlights some central features of this complex but critical area.

In the first section here we describe the limited role given to inequalities in health in *Shaping a healthier future* and how this emerged. We also discuss the emergence of the National Anti-Poverty Strategy (NAPS, 1997) process as it relates to health and how this interfaces with current strategy developments in the Department of Health and Children.

We then turn in the second section to a brief overview of the evidence that currently exists in the Irish context and elsewhere on inequalities in health. This is intended to bring out the scale and importance of these inequalities, the multi-faceted nature of their causes, and the limited information available at present to understand these processes, design policies to tackle them, and monitor progress over time.

In the third section we draw out some of implications that aiming to reduce health inequalities would have for health targets and health policy, focusing in particular on the importance of inter-Departmental policy programmes and multi-sectoral approaches.

In the fourth section we turn to the actual process that should underlie the development of health targets in this area, and discuss the process emerging via the NAPS working groups on health. We argue in particular that there is an urgent need for a co-ordinated information system that delivers timely and accurate policy relevant information using indicators appropriate to the study of inequalities in health.

Health Policy and Inequalities

For decades health policy in Ireland, as in many other countries, has been based on the implicit presumption that the provision of more and better health care services was the most direct means of improving population health, and that the major causes of variations in health across the population were to be found in the distribution of health behaviours such as smoking, drug use, eating patterns and lack of physical exercise.

Such assumptions were built into the 1994 Health Strategy. Although inequalities were mentioned within the underlying principles of the strategy (p. 10), this was only in reference to the goal of equity in health care provision and the need to provide care on the basis of need rather than ability to pay or geographic region. Similarly, in discussing the causes of premature mortality (p. 19), the primary causes of all of the prime conditions were attributed to differential health behaviours. The health targets set out later in the strategy document are thus dominated by target levels of health behaviours to be achieved.

In fact, there is a great deal of research showing that health behaviours offer only a small part of the explanation for variation in mortality and morbidity across socio-economic groups and that, as we will go on to see, socio-economic circumstances should be given much more prominence. This emphasis on health behaviours is not by any means limited to Ireland, but it has been particularly strong here. Health promotion targeting health behaviours are obviously of considerable importance, but constitute only one element in the broader strategy required to effectively target health inequalities.

The goal of equity in access to health care is itself a distinct and important one, both for its own sake and as one way of combating health inequalities. However, it has also been interpreted to date in an unduly limited fashion, seen in practice in geographic terms as relating to resources and availability of services by region. This again is common elsewhere, but fails to adequately address the underlying concern that access to services be equitable across the income distribution or socio-economic groups. This equity objective also needs to be taken directly into account in the way targets and policies are framed.

Concerns over the extent of socio-economic inequalities in health have been receiving greater attention in Ireland, partly reflecting broader trends internationally but also the increased emphasis in domestic policy debate on combating poverty and social exclusion, as crystallised in the emergence of the National Anti-Poverty Strategy (NAPS). This culminated in a commitment under the new partnership agreement – the *Programme for Prosperity and Fairness* (PPF) (Department of the Taoiseach, 2000) – to develop health targets within the NAPS framework. The PPF itself includes the improvement of the health status of the population and the monitoring of socio-economic inequalities in health as two of its core objectives (p. 93). So far, three working groups have been established [within] the Institute of Public Health to examine:

- Equity of access to healthcare
- The impact of public policy on inequalities in health
- Existing health information deficiencies

These working groups are set to recommend specific health targets by June 2001 that, if adopted by the government, can be added to the next NAPS strategy document later this year.

The inclusion of health targets in the NAPS is not the only sign that inequalities in health are now seen as a central concern. The annual report of the Chief Medical Officer of the Department of Health and Children in 1999 stated that "(one) issue above all others is central to our understanding of the experience of our population's health and ill-health, namely the question of health inequality" (Department of Health and Children, 1999, p. 3). The report went on to say that:

> *The multi-dimensional nature of health and ill-health points inexorably to the fact that the solution to what presents as health problems lies in the wider community and that, while the health services have a part to play in our response to this issue, health service provision must be viewed as only one element within a broader context which recognizes the role of multiple influences and participants* (p4).

This changing emphasis has yet to be fully reflected in health policy in Ireland, but as the next section will argue should, as the Chief Medical Officer suggests, become a central focus in future.

The Importance of Socio-Economic Inequalities in Health

The previous section has detailed the increasing emphasis given to inequalities in health in recent years. In this section we briefly review some of the evidence about inequalities in health and the processes involved: this has major implications for the structure of health targets and health policy on which we will be concentrating in the next section.

Across industrialised countries, those who are disadvantaged in terms of income, education or occupational level also tend to be disadvantaged in terms of health status and length of life. Research across a range of countries has consistently shown that those at the bottom of the social class ladder have at least twice the risk of serious illness and premature death as those at the top. Moreover, between the top and the bottom health standards show a continuous social gradient, so those near the top of the ladder have more disease than those at the top, but less than those below them, a pattern repeated all the way down the scale. Research on this subject has been ongoing in a number of countries, but British evidence has been particularly influential internationally. The publication of the Black Report (Townsend and Davidson, 1982) was a watershed in highlighting both the persistence of socio-economic health inequalities and more recently, Sir Donald Acheson's Independent Inquiry into Inequalities in Health (Department of Health, 1998) reports the findings of a large number of studies and documents specific policy proposals (to which we return below).

Research in Ireland on inequalities in mortality rates has not been as extensive as in the UK, but analyses have been published based on matching the population in different socio-economic groups in the 1981 and 1991 census to the numbers of deaths for men around the same time (Nolan, 1990; O'Shea, 1997). As Table 1 illustrates, they show a clear class gradient with the unskilled manual group having about two and a half times the mortality rate of the professional group. Differences in the socio-economic groupings employed do not allow us to directly compare the results with those for other countries but the

pattern looks broadly similar to that found in Britain and indeed in many other European Union countries. [1]

Table 1: Standardised Mortality Ratio by Socio-economic Group, Ireland, Men Aged 15-64 All Causes 1981 and 1991[2]

Social Class	SMR	
	1981	1991
Professional	65	53
Employers and Managers	62	63
Salaried Employees	71	68
Non-Manual Employees	105	86
Skilled Manual	91	85
Semi-Skilled Manual	117	111
Unskilled	163	139
Farmers	79	88
Farm Labourers	86	104
Unknown	174	268

Breaking down these mortality ratios by cause, Table 2 shows that the ratio of deaths between the professional and unskilled manual classes is not however uniform. Whereas malignant neoplasms are 10 per cent more likely among the unskilled manual than the professional group, this differential increases to 142 per cent more for respiratory and 193 per cent more for digestive disorders. Such patterns suggest that there are particular mechanisms that need to be addressed to decrease this inequality in mortality.

Table 2: Ratio Between SMRs for Professional and Unskilled Classes by Different Causes of Death 1991[3]

Cause of Death	Ratio Professional to Unskilled Manual
Diseases of the Circulatory System	1.28
Malignant Neoplasms	1.10
Injury or Poisoning	1.51
Respiratory	2.42
Digestive	2.93

Turning from mortality to morbidity, relatively little research has been carried out on socio-economic inequalities in morbidity in Ireland. Indeed, there are no nationally representative published statistics on the health status of the Irish population that can be used as benchmarks from which we can measure the success or failure of public health measures generally. There are a number of national registers related to particular conditions or types of disease such as the National Cancer Registry, but there are comparatively few nationally representative surveys which include health-related information.

Several national surveys carried out by the ESRI do contain some information on self-reported health status, and (Layte, 2000) for example used the 1994 ESRI survey to examine inequalities in the prevalence of chronic illness among men. Table 3 shows clearly that there is a distinct gradation in the rate of chronic illness among men with those at the top of the social class scale having rates of self-reported chronic illness almost one third lower than men from the unskilled manual class.

Table 3: Standardised Morbidity Ratio by EGP Social Class – Rate of Chronic Illness Among Men

Social Class	SMR
Professional and Managerial	53.84
Routine Non Manual	106.68
Self-Employed	106.72
Farmer	106.08
Skilled	113.71
Unskilled	142.58

This brief overview makes clear, even though evidence is limited, that pronounced and persistent inequalities in health exist in Ireland. What are the underlying causes and how can they best be tackled? As discussed in section one, health care services undoubtedly have an important role to play in improving

[1] Unfortunately female deaths are classified according to their own occupation where this is known, by that of their husband where not, or as full-time carers. Nonetheless, research in the UK has shown that similar differentials exist for women (Davey Smith, Blane, and Bartley 1994).
[2] Figures recalculated from Nolan (1990) and O'Shea (1997).
[3] Figures calculated from O'Shea (1997).

population health and quality of life, but inequities in access to or utilisation of health care services are not the most important determinant of health inequalities. Instead, the social and economic conditions that affect whether people become ill are crucial.

The social gradient in health reflects material disadvantage and the effects of insecurity, anxiety and lack of social integration. Having few resources and assets, often combined with insecure employment and recurrent unemployment, leads to not only material deprivation in terms of poor housing and diet, but also higher levels of anxiety, resignation and fatalism and increased prevalence of coping behaviours such as smoking and drinking. The longer people live in stressful economic and social circumstances, the greater the physiological wear and tear and the less likely they are to enjoy a healthy old age. Even in employment, continuing anxiety and lack of control over one's work situation, particularly when accompanied by chronic insecurity and low self-esteem can have powerful effects on the health of the individual, their social networks and their family. Chronic stress affects the cardiovascular and immune systems and leads in the medium to long term to increased risk of depression, susceptibility to infection, diabetes, hypertension and harmful patterns of cholesterol and fats in the blood that are associated with heart attack and stroke.

Worryingly, evidence also shows that the foundations of adult health are laid in prenatal life and early childhood. Slow growth and a lack of emotional support during this period raise the lifetime risk of poor physical health and reduce physical, cognitive and emotional functioning in adulthood. Poor social and economic circumstances present the greatest threat to a child's growth. A mother's experience of low income, deprivation and chronic insecurity during pregnancy leads to reduced prenatal and infant development, which itself is associated with reduced cardiovascular, respiratory, kidney and pancreatic functioning in adulthood. Parental poverty also leads to higher levels of depression and mental exhaustion which impacts on child development through decreased stimulation of the child and weak emotional attachment. Poor mental, social and emotional development in childhood sets the child on a path of disruptive behaviour in school and low educational attainment and thence to an increased risk of unemployment, insecure work, low social status and poverty. In adulthood then, the health disadvantages of childhood are compounded by further disadvantages, and the disadvantages of one generation are passed on to the next.

This understanding of the scale and causes of health inequalities has major implications for the development of a new health strategy. Rather than seeing health policy as aimed solely at providing more/better health services and persuading individuals to adopt better health behaviours to reduce health inequalities, health policy will also have to aim to create the right *socio-economic structures* and *integrated communities* for health. The implications for the development of a new health strategy are taken up in the next section.

Socio-Economic Inequalities and the Structure of Health Targets

We have emphasised that the main causes of the social gradient in mortality and morbidity are not to be found in access to healthcare services or solely in differentials in health behaviours between social groups. Instead, to reduce health inequalities health policy needs to be seen as just one part of a coordinated policy response that crosses departmental boundaries. This means that any health strategy would of necessity involve innovation in policy formulation and delivery structures.

The National Anti-Poverty Strategy provides a current example where such innovation is being attempted. The institutional structures of the NAPS operate at a number of levels. At the political level, a cabinet sub-committee was established, chaired by the Taoiseach, including ministers from all departments whose briefs were relevant to tackling poverty, but with a key role taken by the Minister for Social, Community and Family Affairs. At the administrative level the NAPS Inter-Departmental Policy Committee was established, jointly chaired by the Department of the Taoiseach and the Department of Social, Community and Family Affairs and staffed by senior civil servants who were to be responsible for ensuring that the NAPS provisions relevant to their departments were implemented. In addition the Combat Poverty Agency and the National Economic and Social Forum were to be responsible for overseeing the evaluation and implementation of NAPS respectively. At the local and regional level it was envisaged that social inclusiveness and equality of opportunity would be fostered through a renewed system of local government. In particular, Community and Enterprise Groups would be responsible for developing plans, including local area action plans which would focus on social exclusion, which may involve the development of local anti-poverty strategies.

However, although the NAPS process has greatly improved the engagement of departments in issues related to poverty, a recent evaluation concluded that this process has not as yet resulted in a coordinated policy response for a number of reasons:[4]

- Insufficient involvement of key individuals, organisations and sectors
- Inadequate structure
- Inadequate resourcing of NAPS Unit and anti-poverty work in general
- Weak political backing
- Inadequate public awareness raising and education
- Lack of ongoing evaluation

If targets were introduced to reduce or eradicate inequalities in health, this would also require a cross-departmental structure not only to produce a coherent strategy, but also to have any chance of successful implementation. The role of the Department of Health and Children in this process would be substantial and quite different from that which it has performed to date. At present the Department's remit is the provision of health care services and the promotion of healthy lifestyles, rather than the development of health- promoting socio-economic and community structures. A coherent health strategy aimed at reducing health inequalities would:

- Seek to develop an understanding in the health care professions and in society generally of the main determinants of health using evidence from the Irish context and more widely.
- "Take ownership" of responsibility for reducing socio-economic inequalities in health.
- Broaden the scope and availability of primary care services. Primary care services account for only a small proportion of health expenditure and are seriously underdeveloped. Instead, this would become a central element in promoting health and social gain by first investigating best practice and seeking to implement healthy work, community and social structures.
- Place the Department of Health and Children in a central role in organising a multi-sectoral strategy to reduce health inequalities.

In this context it is useful to briefly review two health strategies designed to influence socio-economic inequalities that have been developed elsewhere, namely by the UK and the World Health Organisation. Both programmes were informed by current research on inequalities in health and attempted to structure health targets and policies to influence these inequalities at a number of levels.

In 1998, the British Government published a report from the Independent Inquiry into Inequalities in Health chaired by Sir Donald Acheson (Department of Health, 1998), which laid out the extent of and causes of inequalities in the UK context. The report found wide inequalities in health among socio-economic, gender and ethnic groups and laid out 39 main recommendations to reduce inequalities. These included suggestions for changes in tax and benefit systems, the education system including pre-school education, housing and the environment, mobility, transport and pollution and a large number of recommendations aimed at mothers, children and families. The following are just a selection of the policies suggested:

- Establish mechanisms to monitor inequalities in health and evaluate the effectiveness of measures taken to reduce them.
- Recommend a high priority is given to policies aimed at improving health and reducing health inequalities in women of childbearing age, expectant mothers and young children.
- Up-rate benefits and pensions according to principles which protect, and where possible, improve the standard of living of those who depend on them and which narrow the gap between their standard of living and the average.
- Improve nutrition provided at school including provision of free dinners and fruit.
- Assess the impact of employment policies on health and inequalities in health.
- Increase availability of social housing for the less well-off and take into account social networks and access to goods and services.
- Develop a high quality, affordable and integrated public transport system.
- Provide affordable, high quality day care and pre-school education with extra resources for disadvantaged communities.

Also in 1998, the World Health Organisation, European Region adopted a strategy for the new century entitled "Health21" (WHO, 1998), based on the original "Health for All" principles launched in 1984 and revised in 1991. As the title suggests the new strategy had 21 items and placed emphasis on equity and national and local inter-sectoral collaboration. Examples of targets from the strategy include:

- The gap in life expectancy between socio-economic groups should be reduced by at least 25 per cent.

[4] See Johnston and O'Brien (2000) p. 42.

- The values for major indicators of morbidity, disability and mortality in groups across the socio-economic gradient should be equitably distributed.
- Socio-economic conditions that produce adverse health effects, notably differences in income, educational achievement and access to the labour market, should be substantially improved.
- The proportion of the population living in poverty should be greatly reduced.
- People having special needs as a result of their health, social or economic circumstances should be protected from exclusion and given easy access to appropriate care.

These provide concrete examples of both the nature and scope of the targets required in this particularly challenging area. It is not part of our brief to recommend specific targets best suited to the Irish context, but we will discuss in the next section criteria against which such targets should be assessed in the course of development.

The Targeting and Strategy Process

Developing a health strategy is a complex undertaking and there is no one best approach. However, a research literature (c.f. Van Herten and Gunning-Shepers, 2000) has examined at a general level what makes for an effective process of policy and strategy development, and abstracted some underlying principles. It is worth considering the process already in train for development of the health strategy and the health elements of the NAPS in this light.

First and foremost, policy should emerge after a period of research and discussion that examines in depth the patterns of the phenomena of interest and seeks to explain these patterns through systematic evaluation of evidence. This means carrying out independent and scientifically valid research that will form the basis of understanding. Social and economic policy relies upon accurate information and research to supply the "levers" needed for effective intervention. For example, the Independent Inquiry into Inequalities in Health in the UK spent a year assessing a wide range of evidence that was already available from a large number of research projects in the UK before coming to conclusions in its final report.

In contrast, the NAPS working party groups on health in progress at the time of writing will have barely six months to understand the nature of the processes at work using an extremely limited information base before developing targets for health. Similarly, the Department of Health and Children will be developing a new health strategy document for mid-2001, but again with a very limited research and information base and with a relationship to the NAPS process which is at present unclear. There is a fundamental weakness in the data available on health in Ireland at present, and the urgent need for research to inform policy and for data against which success in meeting targets can be monitored.

Setting concrete targets is the next stage in the process. These targets need to satisfy a number of criteria if they are to be effective. It is commonly accepted that targets should be:

- Specific
- Measurable
- Achievable
- Realistic
- Time bound

While these may appear obvious or innocuous at first sight, it is striking that the majority of the sub-targets currently adopted in the NAPS do not meet these criteria (see Nolan, 2000). Particularly given the paucity of baseline information, it will be difficult to develop specific and measurable targets in the area of health inequalities. The best approach to adopt at this stage would be a parallel process, which both sets specific and measurable targets in terms of outcomes on which baseline information is available, and seeks at the same time to significantly improve the range of data being gathered. Throughout the healthcare system a large quantity of data is collected that could be invaluable for use in research on health inequalities and monitoring progress. However, at present it is of little use in that context because the appropriate, or even minimal, socio-economic information is not obtained on individuals, for example when use of health services is recorded. As a priority, the health strategy should establish a consultation process to review current and future information needs. Minimum specifications for types of socio-economic data to be collected should be established so that more efficient use can be made of current information. Greater coordination in information systems should also be promoted, since much more could be achieved if databases were much more closely integrated.

To be effective, targets directed at tackling inequality must be accompanied by specific and detailed plans of action and implementation, again using the understanding distilled from the research base to develop the most appropriate means. Once again, the limitations of the current Irish knowledge base cannot be allowed to delay the development of concrete policy initiatives: it will be necessary to draw on

what has been learned elsewhere about causal processes and effective policies, while at the same time seeking to improve the domestic knowledge base.

The next phase is the implementation of the strategy, which will as we have emphasised entail institutional innovation and a new role for the Department of Health and Children. Following implementation it is crucial that a monitoring process be established, and progress reviewed after a set period. The review can assess not only whether the targets have been achieved, but also whether they were appropriate at inception and possibly need to be revised. The review and monitoring process can also assess whether the initial understanding of the processes involved was correct and the implications this has for the strategy. Finally, the monitoring process would assess whether the means taken to achieve the targets was efficient and cost effective in a broad sense. In the light of all of these considerations targets and strategy can then be revised or confirmed.

Conclusions

The health strategy published in 1994 paid relatively little attention to socio-economic health inequalities, an area that has now come much more to the fore and will probably receive much greater prominence in a new health strategy for Ireland, as it has elsewhere. *Shaping a healthier future* also placed most of its emphasis on delivering more and better health services and on promoting healthy behaviours. Setting targets for equity in terms of access to and use of the health services, and designing funding and delivery systems that allow those targets to be attained, is indeed of central importance in its own right. However, while ensuring equity in access and promoting healthy living have important roles to play, tackling health inequalities effectively requires a much more broad-ranging approach and a new role for the Department of Health and Children.

While the evidence for Ireland is limited, it suffices to show that pronounced and persistent health inequalities exist here as in other industrialised countries. Health inequalities reflect underlying differences in socio-economic circumstances, and new institutional mechanisms will have to be found to allow the Department of Health and Children to lead a coordinated and coherent cross-departmental strategy aimed at reducing those inequalities.

Examples of the way such a strategy has been formulated elsewhere, discussed in this chapter, can be drawn on in focusing Ireland's new health strategy firmly on reducing health inequalities, but a great deal of new thinking also remains to be done. This is the case in terms of establishing baselines and targets, improving our understanding of processes, and designing structures that suit the domestic policy context and can be effective. The National Anti-Poverty Strategy, though itself still evolving towards greater effectiveness, offers some interesting examples of institutional innovation.